I’m writing to oppose and offer feedback to the Centers for Medicare & Medicaid Services on the recent changes to its research data request and access policy. On February 12th, the agency abruptly and unexpectedly announced it will limit access to Medicare and Medicaid claims data and even increase fees imposed on individual researchers seeking access to this data for their investigations. I understand that these changes came in response to increased data security breaches, but I also know that researchers take patient-level data seriously and already utilize the highest-level security protocols and tools to protect data security and integrity. For this reason, I strongly believe that an increase in security is not necessary or appropriate when weighed against the potential harm this change could have on the Medicare program.

Access to Medicare and Medicaid claims data is critical to both clinical advancement and policy refinement; it enables researchers to advance rehabilitation science through analysis of treatment patters or coverage of services that are highly effective for Medicare beneficiaries. Using this data, researchers across the country have published [countless high-impact studies,](https://docs.google.com/document/d/1H-27k-tn3jQJ65UUvMRr1vgW3KVIGoYdOqihzTYpG0k/edit) many of which have led to breakthroughs in medical treatment and shifts in health care coverage that have improved the lives of patients and saved both Medicare and taxpayer dollars. [APTA’s groundbreaking “Economic Value of Physical Therapy in the United States” report](https://www.valueofpt.com/) relied on peer-reviewed randomized controlled trials that compare physical therapy services with an alternative method of care. Many of the articles collected for the economic analysis of this report are examples of high-value literature that rely on comparative analyses of Medicare claims data for the purpose of examining and defining the value of Medicare services for specific conditions. Both the results of the APTA report and analytics from each individual study are only possible when researchers have ready access to claims data via the two options available through the current policy.

I am especially concerned that the increase of existing fees and the addition of new project fees will force many research institutions to reevaluate research priorities, and pare down, or even terminate ongoing investigations. CMS also needs to acknowledge that although well-resourced institutions will lose access to large quantities of physical data extracts, their stable and ample funding streams insulate them from the most severe impacts of these changes. Rather, smaller universities and research centers will bear the brunt of these changes, which are certain to impact the career opportunities of individuals from underrepresented backgrounds. This is concerning to me and my colleagues in the research community because larger research teams create more interdisciplinary collaboration and provide more opportunities to check code and train junior team members. I have significant apprehension about both the short- and long-term quality of physical therapy research if this policy encourages institutions to rely on smaller teams rather than larger research projects that utilize multiple analysts for rigor and reliability.

Additionally, the CMS Chronic Conditions Warehouse Virtual Research Data Center (VRDC) is not a sustainable research warehouse. It has restrictions on the available coding languages, limited server capacity, and controls the number of times researchers can produce outputs. I am worried about this impact this could have on data analysis and interoperability. If CMS were to permanently discontinue access to physical data extracts, specific research streams could suffer because certain research approaches depend upon analyses that cannot be conducted in the VRDC environment. I hope that innovation is not compromised when physical data extracts become obsolete.

For these reasons, I believe that the agency has not fully considered how these new policies will restrict data access and fundamentally limit healthcare research in the United States. Applying such a large-scale solution to target a select number of bad actors is more likely to limit the capacity of institutions to serve CMS’ broader goals of improving healthcare quality, efficiency, and equity in the United States than it is to improve overall data security. Before considering the removal of physical data extracts, I ask CMS not to implement these changes and instead conduct listening sessions with researchers, create a reasonable fee structure that doesn’t encourage academic inequities, and actively work to fix the limitations in the VRDC environment. In total, I ask the agency to reevaluate the impact of these changes that impede evidence-based research and encourage the agency to focus on how to improve access to data with the goal of elevating high-value Medicare services.